Commonwealth INDEMNITY PLAN

For Retired Municipal Teachers & Elderly Governmental Retirees

Benefit Updates and Important Information

SERIES 3
EFFECTIVE
JULY 1, 2007

Commonwealth of Massachusetts
Group Insurance Commission

UniCare®

Updates to the Commonwealth Indemnity Plan Member Handbook

This booklet contains important updates to your Commonwealth Indemnity Plan coverage (with or without CIC), effective July 1, 2007. Please keep this year's Benefit Update—together with the Series 3 Member Handbook ("Member Handbook") and the Series 3 Benefit Updates ("Benefit Updates") for 2004, 2005 and 2006—in a convenient place for easy access when you need to refer to your health plan information.

This Benefit Update is also available on the Plan's web site: **www.unicare-cip.com** (click on "Forms and Documents"). It will also be incorporated into the next printed revision of the Member Handbook.

If you have any questions about these changes, please call the Commonwealth Service Center at **(800) 442-9300**, Monday through Thursday from 8:30 a.m. to 6:00 p.m., and Friday from 8:30 a.m. to 5:00 p.m. You can also email us from our web site: **www.unicare-cip.com** (click on "Contact Us"). If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A customer service representative will be happy to help you.

Important: Certain changes in this update apply **only to non-Medicare eligible members**; the rest apply to **both non-Medicare and Medicare eligible members.** Please look for the following headings to be sure you are reading the information that applies to you:

For Non-Medicare Eligible Members Only (pages 2-10)

For Both Non-Medicare Eligible & Medicare Eligible Members (pages 10-19)

For Non-Medicare Eligible Members Only

Benefit Changes

Inpatient Hospital Quarterly Deductible

The inpatient hospital deductible is waived for readmissions that occur within 30 days following a hospital discharge, within the same calendar year. This change is reflected in the Member Handbook as follows:

A. The subsection titled, "Inpatient Hospital Quarterly Deductible" in the Your Costs section on page 9 of the Member Handbook is deleted and replaced with the following:

Inpatient Hospital Quarterly Deductible

The inpatient hospital quarterly deductible applies on a per-person, per-calendar year quarter basis. Each time you or a covered dependent is admitted to a hospital, you are responsible for this deductible. However, once a covered person satisfies this deductible in any single calendar year quarter, he or she will not have to satisfy the deductible again during the same calendar year quarter. In addition, the inpatient hospital deductible is waived for readmissions that occur within 30 days following a hospital discharge, within the same calendar year (even if the two admissions occur in different calendar year quarters).

Example 1: If you have coverage with CIC and are admitted to a hospital in January and stay overnight, you will be responsible for paying the $150 deducible. If you are readmitted in March, you will not be responsible for another deductible, as March is in the same calendar year quarter as January. However, if you are readmitted in May, you will incur another $150 deductible.

Example 2: If you are admitted to the hospital at the end of March and then readmitted in April (within 30 days of your March discharge), you will not be responsible for another deductible. But if you are readmitted in May (more than 30 days from your March discharge), you will incur another $150 deductible.

Example 3: If you are admitted to the hospital at the end of December and are readmitted in the beginning of January, you will be responsible for another deductible because the admissions were not in the same calendar year (even though the two admissions occur within 30 days of each other).

B. The charts in the Your Costs section on page 8 of the Member Handbook and on page 3 of the 2006 Benefit Update are deleted and replaced with the following:

Deductible	Coverage Without CIC (non-comprehensive coverage)	Coverage With CIC (comprehensive coverage)
Inpatient Hospital Quarterly Deductible[1] (per person)	$250	$150
Outpatient Surgery Quarterly Deductible (per person)	$75	$75

[1] The inpatient hospital deductible is waived for readmissions that occur within 30 days following a hospital discharge, within the same calendar year.

Calendar Year Deductible

The individual and family calendar year deductibles are eliminated for non-Medicare eligible members. The following changes are made to the Member Handbook to reflect this change:

A. The charts in the Your Costs section on page 8 of the Member Handbook and on page 3 of the 2006 Benefit Update are deleted and replaced with the revised chart above.

B. The text regarding the family calendar year deductible is deleted from page 4 of the 2006 Benefit Update. In addition, the following subsections are deleted from the Your Costs section of the Member Handbook:

- "Individual Calendar Year Deductible" on page 8
- "Family Calendar Year Deductible" on page 9
- "Deductible Carryover" on page 9

C. The term "calendar year deductible" is deleted from the "Copayments" subsection in the Your Costs section on page 9 of the Member Handbook and on page 4 of the 2006 Benefit Update. See Item B on page 5 of this booklet for the fully revised "Copayments" subsection.

D. References to the calendar year deductible are deleted in the following summaries of covered services in the Benefit Highlights section of the Member Handbook:

- Other Inpatient Facilities on page 27
- Non-Emergency Treatment on page 28
- Outpatient Medical Care on page 29
- Physician Services on page 30
- Private Duty Nursing on page 30
- Home Health Care on page 31
- Home Infusion Therapy on page 31
- Preventive Care on page 31
- Hospice on page 32
- Ambulance on page 32
- Coronary Artery Disease (CAD) Secondary Prevention Program on page 32
- Durable Medical Equipment (DME) on page 33
- Hospital-Based Personal Emergency Response System (PERS) on page 33
- Prostheses on page 34
- Braces on page 34
- Hearing Aids on page 34
- Eyeglasses/Contact Lenses on page 34
- Family Planning Services on page 34
- All Other Covered Medical Services on page 34

Physician Office Visit Copayments

Effective July 1, 2007, Commonwealth Indemnity Plan Basic members will pay a $10 copay for office visits to "Select" physicians in Massachusetts—both primary care doctors and specialists—and a $20 copay for visits to all other physicians. Physicians designated as Select are those who have demonstrated quality and/or efficiency in their practices. You'll find more information on physician designation and Select physicians at **www.unicare-cip.com** (click on "Forms and Documents").

Please note that physician designation does not apply to visits to chiropractors, physical therapists or occupational therapists. Copays for these services are $15 (see "Copayment for Chiropractic Care" and "Physical and Occupational Therapy" on page 7 of this booklet.)

This change to physician office visit copays is reflected in the Member Handbook as follows:

A. The following bulleted text is added under "How to Receive the Highest Level of Benefits from Your Medical Plan" on page 5 of the Member Handbook:

- To save on out-of-pocket costs for physician office visits, use Select physicians in Massachusetts—those physicians who have demonstrated quality and/or efficiency in their practices. To find out if your physician is a Select physician, log onto the Plan's web site: **www.unicare-cip.com** and click on "Find a Provider." Select the link for the Basic Plan, and then the link for "Select Physician Listing for Basic Members." Or call the Commonwealth Service Center at (800) 442-9300 for assistance.

B. The subsection "Copayments" in the Your Costs section on page 9 of the Member Handbook and on page 4 of the 2006 Benefit Update is deleted and replaced with the following:

Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the type of service you receive. Copayments do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

For example: If you are a member of the Commonwealth Indemnity Plan Basic with CIC and you or a covered dependent go to a physician's office, you or your dependent will pay a $10 copay for Select physicians in Massachusetts at the time of the visit, and a $20 copay for all other physicians. Select physicians are those who have demonstrated quality and/or efficiency in their practices. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is the $50 copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital quarterly deductible will apply.

C. The coverage for physician services in the Benefit Highlights section on page 30 of the Member Handbook and on page 5 of the 2006 Benefit Update is deleted and replaced with the following:

	Without CIC	With CIC
Physician Services		**Also see page 71**
Non-emergency Treatment at Home, Office or Outpatient Hospital	80% after a $10/20[1] copay per visit. The copay does not count toward the out-of-pocket maximum.	100% after a $10/20[1] copay per visit. The copay does not count toward the out-of-pocket maximum.
Hospital Inpatient	80%	100%
Emergency Treatment	80%	100%
Chiropractic Care or Treatment	80% after a $15 copay per visit; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance does not count toward the out-of-pocket maximum.	80% after a $15 copay per visit; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance does not count toward the out-of-pocket maximum.

D. The following footnote is added to the Benefit Highlights section on page 30 of the Member Handbook:

[1] Members pay a $10 office visit copay for Select physicians in Massachusetts and a $20 office visit copay for all other physicians. (To find out if your physician is a Select physician, see the instructions in Item A on page 4 of this booklet.) Members pay a $15 copay for all visits to chiropractors, physical therapists and occupational therapists.

E. The coverage for preventive care in the Benefit Highlights section on page 31 of the Member Handbook and on page 6 of the 2006 Benefit Update is deleted and replaced with the following:

	Without CIC	With CIC
Preventive Care		🕮 **Also see page 72**
Office Visits (refer to frequency limits on page 72)	100% after a $10/20[3] copay per visit. The copay does not count toward the out-of-pocket maximum.	100% after a $10/20[3] copay per visit. The copay does not count toward the out-of-pocket maximum.
Annual Gynecological Visits	100% after a $10/20[3] copay per visit	100% after a $10/20[3] copay per visit
Immunizations	100%	100%
Laboratory Testing[4]	100%	100%

F. Footnote number 4 on page 6 of the 2006 Benefit Update, which was added to the Benefit Highlights section on page 31 of the Member Handbook, is deleted and replaced with the following footnote:

[3] Members pay a $10 office visit copay for Select physicians in Massachusetts and a $20 office visit copay for all other physicians. (To find out if your physician is a Select physician, see the instructions in Item A on page 4 of this booklet.) Members pay a $15 copay for all visits to chiropractors, physical therapists and occupational therapists.

Footnote 3 on page 6 of the 2006 Benefit Update is renumbered as footnote 4.

G. The coverage for family planning services in the Benefit Highlights section on page 34 of the Member Handbook is deleted and replaced with the following:

	Without CIC	With CIC
Family Planning Services		🕮 **Also see page 69**
Office Visits and Procedures	100% after a $10/20[3] copay per visit	100% after a $10/20[3] copay per visit

H. The following footnote is added to the Benefit Highlights section on page 34 of the Member Handbook:

[3] Members pay a $10 office visit copay for Select physicians in Massachusetts and a $20 office visit copay for all other physicians. (To find out if your physician is a Select physician, see the instructions in Item A on page 4 of this booklet.) Members pay a $15 copay for all visits to chiropractors, physical therapists and occupational therapists.

I. The following definition is added to the Plan Definitions section on pages 82-88 of the Member Handbook:

"Physician Designation" – Physician designation gives members access to "Select" physicians in Massachusetts for a lower office visit copay. These physicians have been designated as Select because they have demonstrated quality and/or efficiency in their practices. For all other physicians, members pay the standard office visit copay, which is higher.

Copayment for Chiropractic Care

The copayment for chiropractic care is $15 per visit. This change to the Benefit Highlights section on page 30 of the Member Handbook and to page 5 of the 2006 Benefit Update is reflected in the revised coverage summary for Physician Services (Item C) on page 5 of this booklet.

Physical and Occupational Therapy

Physical and occupational therapy are covered at 100% after a $15 copay per visit. This change to the Member Handbook is reflected in the revised coverage summary for Outpatient Medical Care (Item B) on page 8 of this booklet.

Outpatient Laboratory Services

You are covered at 100% for services received from all outpatient laboratory vendors, not just for those services received from the Plan's preferred laboratory vendors. This change is reflected in the Series 3 Member Handbook as follows:

A. The second bulleted item under "How to Receive the Highest Level of Benefits from Your Medical Plan" on page 5 of the Member Handbook is deleted and replaced with the following:

- Use the Plan's Preferred Vendors for the following services to enhance your level of benefits:
  - durable medical equipment
  - medical/diabetic supplies
  - home health care
  - home infusion therapy

B. The coverage summary for Outpatient Medical Care in the Benefit Highlights section on page 29 of the Member Handbook is deleted and replaced with the following:

	Without CIC	With CIC
Outpatient Medical Care		**📖 Also see pages 67-73**
For Services at a Hospital (other than the services listed below)	100%	100%
Diagnostic Laboratory Testing	100%	100%
Radiology	80%	100%
☎ Physical Therapy and ☎ Occupational Therapy	100% after a $15 copay per visit	100% after a $15 copay per visit
Speech Therapy (as described in the Description of Covered Services)	80% up to a maximum benefit of $2,000 per calendar year	100% up to a maximum benefit of $2,000 per calendar year
Chemotherapy	80%	100%

C. Footnotes 1 and 2 are deleted from the Benefit Highlights section on page 29 of the Member Handbook.

Appendices

Appendix B, "What You Should Know When You Use Non-Massachusetts Providers," in the Appendices section on page 127 of the Member Handbook and on pages 2-3 of the 2004 Benefit Update, is deleted and replaced with the following:

What You Should Know When You Use Non-Massachusetts Providers
You have access to network providers if you live outside of Massachusetts or when you travel outside your state of primary residence. When you use these providers, you will not be balance billed for your care.

This appendix contains important information about access to UniCare's out-of-state contracted providers for members who reside outside of Massachusetts or are traveling outside of Massachusetts. It also describes how the Commonwealth Indemnity Plan pays for services you receive from health care providers located outside of Massachusetts that are not part of the UniCare out-of-state provider network.

How the Plan Reimburses Out-of-state Providers
The Commonwealth Indemnity Plan pays out-of-state providers according to fee schedules that establish allowed rates for payment of services. Our goal is to provide adequate compensation that is in line with prevailing payments made by other health insurance payers.

Although we believe our payments are fair and equitable, certain providers that are not part of the UniCare network might bill you for the difference between the payments made by the Plan according to the fee schedules and the charges they submit to the Plan. This is called balance billing. We hope and expect that most providers will be reasonable in their demands for payment. We encourage you to speak with your providers regarding their policies on balance billing.

Helping You Avoid Balance Billing
To help you avoid balance billing, we created the UniCare Preferred Program (UPP). This program gives you access to UniCare's network of contracted providers—**except for mental health/substance abuse providers**. These providers accept our fee schedules as payment in full and agree not to balance bill you.

If you reside outside of Massachusetts, you will receive a UPP card from the Plan. To use the UPP program, you must show your UPP card when you see a participating provider. Use your Commonwealth Indemnity Plan ID card for visits to all other providers—including when you use UniCare network providers when you are traveling.

How to Find a UPP Provider
For a list of providers available to you under the UniCare Preferred Program, please check the online provider finder at **www.unicare-cip.com**. The provider finder will help you identify out-of-state providers that will not balance bill you for your care.

Important: **If you need mental health/substance abuse treatment or the Enrollee Assistance Program (EAP), you must contact United Behavioral Health (UBH), the administrator for these services. You will be subject to balance billing if you use a mental health/substance abuse provider that is not in the UBH network.**

Here's how to use the UniCare online provider finder to locate providers (other than mental health/substance abuse providers):

- Log onto **www.unicare-cip.com**.
- Click on **"Find a Provider"** on the home page.
- Select the link, **"out-of-state residents and travelers."**
- Select the link **"find a UniCare out-of-state provider"**on the Provider Search page; then click on the link to search for a UniCare out-of-state provider and follow the directions provided.

What to Do if Your Provider Is Not Part of the UPP Network
If you do not find your provider's name in the UPP online provider directory and you continue to see that provider, you may be balance billed for charges in excess of the Commonwealth Indemnity Plan's allowed amount. To ensure that you will not be balance billed, you can switch to a network provider for future care.

You may wish to speak with your provider about joining the UPP provider network so you can continue to see this provider without the risk of being balance billed. Your provider can call UniCare Customer Service at **(800) 333-3304** for information.

For Both Non-Medicare & Medicare Eligible Members

Benefit Changes

Coverage for Dependent Children and Full-time Student Dependents

The eligibility for dependent children age 19 and over is changed as follows:

A. Item 6 under "Dependent" in the Plan Definitions section on page 83 of the Member Handbook is deleted and replaced with the following, and items 7 and 8 are added:

6. An unmarried dependent age 19 or over, but under age 26, who qualifies as a dependent under the Internal Revenue Code
7. An unmarried dependent age 19 or over until the earlier of two years following the loss of dependent status under the Internal Revenue Code or age 26, whichever comes first
8. An unmarried full-time student, as determined by the GIC, until age 26. At age 26, a full-time student may elect to continue coverage as an individual under the Commonwealth Indemnity Plan and pay 100% of the required premium. That student must file a written application with the GIC, and the application must be approved by the GIC, or

B. Item 7 under "Dependent" in the Plan Definitions section on page 83 of the Member Handbook is renumbered, becoming Item 9.

C. The description for full-time student under "Application for Coverage" in the General Provisions section on page 89 of the Member Handbook is deleted and replaced with the following:

Continued Dependent Coverage

An unmarried dependent child who reaches age 19 is no longer automatically eligible for coverage. In order to continue coverage for a dependent age 19 and over, you must complete both of the following steps:

1. Complete the application that will be sent to you by the GIC prior to the dependent's 19th birthday. Return the completed application as instructed on the form. If the application is returned late, your dependent may have a gap in coverage.
2. Complete subsequent eligibility recertification forms. Return the completed forms as instructed on the form. If the forms are returned late, your dependent may have a gap in coverage.

D. The subsection "When Coverage Ends for Dependents" in the General Provisions section on page 90 of the Member Handbook is deleted and replaced with the following:

When Coverage Ends for Dependents

A dependent's coverage ends on the earliest of:

1. the date your coverage under the Commonwealth Indemnity Plan ends
2. the end of the month covered by your last contribution toward the cost of such coverage
3. the date you become ineligible to have dependents covered
4. the date the enrollment period ends
5. the date the dependent ceases to qualify as a dependent
6. the date the dependent begins active duty in the armed forces of the United States
7. the date the dependent marries
8. the date of the dependent's death, or
9. the date the Commonwealth Indemnity Plan terminates

Benefit Clarifications

Limitations

Item 5 in the Limitations section on page 80 of the Member Handbook is deleted and replaced with the following:

5. Cosmetic procedures/services are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury.

Important Plan Information

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. parent education
2. assistance and training in breast or bottle feeding, and
3. performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

Coverage for Reconstructive Breast Surgery

If you elect breast reconstruction in connection with mastectomy, you also are covered for the following, in a manner determined in consultation with the attending physician and the patient:

1. all stages of reconstruction of the breast on which the mastectomy has been performed
2. surgery and reconstruction of the other breast to produce a symmetrical appearance
3. prostheses treatment for physical complications of all stages of mastectomy, including lymphedemas

Benefits will be payable on the same basis as any other illness or injury under the group policy, including the application of appropriate deductibles and coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.

Involuntary Disenrollment Rate

In accordance with Division of Insurance regulations, UniCare reports that its involuntary disenrollment rate among its members for its Massachusetts book of business was 0 percent in 2006.

Do You Have Coverage under Another Health Plan?

If you have medical benefits under another health plan in addition to the Commonwealth Indemnity Plan, you need to let us know by completing our "Other Health Insurance" form. This way, we can work with the other health plan to determine which plan has primary responsibility for providing coverage for each service. **(Please note: Medicare is not considered an additional health plan if you are a member of the Medicare Extension Plan.)**

This is called "coordination of benefits (COB)." This provision lets members with coverage under another plan use the coverage available to them under **all** health plans they are enrolled in.

You must also complete the Other Health Insurance form if any of your **family members** covered under the Commonwealth Indemnity Plan also have medical benefits under another health plan.

Important: **You do not have to complete the Other Health Insurance form if you only have health plan coverage under the Commonwealth Indemnity Plan. Also, it is not necessary to tell us about coverage under:**

- Medicare (if you are a Medicare Extension Plan member*)
- MassHealth
- Tricare, or
- other types of coverage such as dental, vision or life insurance plans

* If you, or a family member who has the Commonwealth Indemnity Plan Basic, are enrolled in Medicare Part A or B and are not a Medicare Extension Plan member, you must complete the Other Health Insurance form.

How to Get a Copy of the Other Health Insurance Form

- ***New* Plan Members:** You'll find a copy of this form in your welcome package.
- ***Renewing* Plan Members:** You can download this form from our web site: **www.unicare-cip.com** by clicking on the link for the Other Health Insurance form on the Forms and Documents web page. Or call the Commonwealth Service Center at (800) 442-9300 to request the form.

Need Help?

If you're not sure whether you need to complete the Other Health Insurance form, a customer service representative can help you. Please call (800) 442-9300.

Prescription Drug Benefit Plan

Administered By:

EXPRESS SCRIPTS®

www.express-scripts.com

Description of Benefits

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan.

If you have any questions about your prescription drug benefits, contact the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-855-2881).

Beginning July 1, 2007, all specialty drugs must be filled through Express Scripts' specialty pharmacy, CuraScript. The following updates incorporate changes in your coverage for specialty drugs.

About Your Plan

The subsection, "About Your Plan" in the Express Scripts section on pages 10-11 of the 2005 Series 3 Benefit Update, and all of the information on page 11 of the 2006 Series 3 Benefit Update, is deleted and replaced with the following:

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter version of Prilosec® (Prilosec OTC®), medications are covered only if a prescription is required for their dispensing. Diabetic supplies are also covered by the plan.

The plan categorizes medications into five major categories:

Generic Drugs
Generic prescription drugs have the same active ingredients in the same dosage form and strength as their brand name counterparts. The FDA approves both brand name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand name drugs. These requirements assure that generic drugs are as safe and effective as brand name drugs.

Preferred Brand Name Drugs
A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Non-Preferred Brand Name Drugs
A non-preferred brand name drug, or non-formulary drug, is a medication that usually has a therapeutic alternative generic or preferred brand name drug.

Specialty Drugs
Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

Over-the-Counter (OTC) Drugs
Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC® (which is covered if dispensed with a written prescription).

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

Copayment for	Participating Retail Pharmacy up to 30-day supply	Home Delivery up to 90-day supply
Tier 1 **Generic Drugs *and*** • Prilosec OTC® *(28-day supply – retail; 84-day supply – mail)** • Excluding omeprazole *(acid reducer)*	$7	$14
Tier 2 **Preferred Brand Name Drugs *and*** • omeprazole	$20	$40
Tier 3 **Non-Preferred Brand Drugs *and*** • COX-2 inhibitors *(pain and inflammation - Celebrex®)* • Brand name proton pump inhibitors *(acid reducer: Aciphex®, Nexium®, Prevacid®, Protonix®)*	$40	$90
Value Tier • Generic Statin *(cholesterol lowering – lovastatin)* • Generic H-2 antagonists *(acid blockers – cimetidine 300, 400 and 800mg; famotidine 40mg; nizatidine 150 and 300mg; ranitidine 300mg)*	$2	$4

NEW

Copayment for	Filled Only Through CuraScript
Specialty Drugs	$10 up to a 30-day supply

**due to manufacturer packaging*

Effective July 1, 2007, all specialty drugs must be filled through CuraScript pharmacy.

Filling Your Prescriptions

The subsection "Filling Your Prescriptions" in the Express Scripts section on page 12 of the 2005 Series 3 Benefit Update is deleted and replaced with the following:

Filling Your Prescriptions

You may fill your prescriptions at a participating retail pharmacy or through Express Scripts Home Delivery (Mail Order). Prescriptions for specialty drugs must be filled through CuraScript.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts ID card, with the exception of the limited circumstances detailed in the "Claim Forms" subsection on page 13 of the 2005 Series 3 Benefit Update.

Specialty Pharmacy

The following subsection is inserted in the Express Scripts section on page 13 of the 2005 Series 3 Benefit Update, following the subsection "Using Home Delivery":

Express Scripts' Specialty Pharmacy

CuraScript is a full-service specialty pharmacy that provides personalized care to each patient. **As of July 1, 2007, all specialty drugs must be filled through CuraScript pharmacy.** Your copayment for these drugs is $10 for up to a 30-day supply. To assist you in transitioning your specialty drug(s) to CuraScript, you will be allowed two fills of your specialty drug(s) at a participating retail pharmacy. After these two fills, your specialty drug(s) will no longer be covered through other pharmacies.

CuraScript offers a complete range of services and specialty drugs – many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer all of your specialty drug questions. A patient care coordinator will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CuraScript, call CuraScript toll free at (866) 848-9870.

CuraScript Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office or other approved location
- **Refill Reminders** – Ongoing refill reminders from a patient care coordinator
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

CuraScript services a wide range of patient populations, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, post-transplant needs and more.

Specialty Medications

The subsection, “Specialty Medications” in the Express Scripts section on pages 16-17 of the 2005 Series 3 Benefit Update is deleted.

Definitions

The following definition for specialty drugs is added to the Definitions subsection in the Express Scripts section on pages 17-18 of the 2005 Series 3 Benefit Update:

Specialty Drugs – Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs

Effective July 1, 2007

The following information is provided as a clarification to the information found in the Series 3 Member Handbook. This Benefit Update is effective as of July 1, 2007.

Within the section titled "Network Benefits" in "Part III – Benefits Explained," please replace the subsection "Inpatient Care" on page 117 of the Series 3 Member Handbook with the following subsection:

Inpatient Care – Network inpatient care deemed to be a *covered service* in a general or psychiatric hospital, or substance abuse facility if *precertified*, is covered at 100% after a $150 per calendar quarter deductible for members without Medicare and $50 per calendar quarter deductible for members with Medicare Extension (OME). The deductible is waived if readmitted within 30 days, with a maximum of one deductible per calendar quarter. There is a $200 *non-notification penalty* for failure to precertify inpatient care.

Within the section titled "How to Initiate a First Level Internal Appeal (Grievance) Review" in "Part I – How to Use This Plan," please replace the UBH appeals address on page 109 of the Series 3 Member Handbook with the following:

United Behavioral Health, Appeals Unit
Post Office Box 32040
Oakland, CA 94604-3340
Tel: 800-985-2410
Fax: 415-547-6259

PO Box 9016
Andover, MA 01810-0916

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Important Information Enclosed
Please Read